AUTHORIZATION TO RELEASE INFORMATION FROM THE ADULT/CHILD PROTECTIVE SERVICES CENTRAL REGISTRY

DHS 1507
INSTRUCTIONS

PURPOSE:

DHS 1507 shall be completed by individuals who are requesting the release of information from the Protective Services Central Registry of the Adult and Community Care Services (ACCS) Branch and the Child Welfare Services (CWS) Branch. By completing this form, the individual authorizes the Department of Human Services (DHS) or its designee to conduct a Protective Services Central Registry Check and to release the information to the individual or to a third party as specified by the individual.

SPECIFIC INSTRUCTIONS: **PRINT LEGIBLY IN BLACK INK OR TYPE ALL ENTRIES.** DHS or its designee shall return the form for clarification if entries are unreadable.

1. *Check only one* of the programs that applies to your application for employment, licensure, certification, or to become a volunteer.

2. *Enter* the individual or agency to whom the information is to be released and the address where the information is to be sent. When information is being released to an agency, *enter* the name of the individual within the agency who is to receive the information, if applicable.

3. *Check* the appropriate box(es) for the Protective Services Central Registry Check(s) that you are requesting. Depending upon the program or agency that is requiring you to have a Protective Services Central Registry Check, you may be checking the Adult Protective Services (APS) box, the Child Abuse and Neglect (CAN) box, or both. If you are not sure which box(es) to check, please ask your program or agency.

4. *Enter* your full name, date of birth, social security number, telephone number, any aliases including maiden name, and current address.

5. **Authorization to release information:** Read the information within the box and *enter* the date or the event when you wish the authorization to expire. Note that the authorization will expire one year from the date you sign the form if no date or event is included. *Sign and date* the form at the bottom of page 1 in the spaces provided.

6. *Mail or FAX* the completed form to DHS' designee:
   Insights to Success, Inc. (ITS)
   P. O. Box 1290
   Honolulu, Hawaii 96807
   FAX #: 532-8331

DHS OR DHS DESIGNEE RESPONSIBILITY: In the "FOR OFFICIAL USE ONLY" section on page 2:

1. *Print* the full name and date of birth of the requesting individual.

2. *Complete* the APS/CAN Central Registry Clearance and *check* the appropriate box(es) indicating the results of the clearance. *Write in* the dates of confirmation as applicable.

3. *Enter* the name of the worker completing the clearance and the worker's phone number.

4. *Enter* the date the clearance was completed.

5. *Retain* the ORIGINAL completed DHS 1507 and *file* for future reference.

6. *Mail* a photocopy of the completed DHS 1507 to the requesting individual or agency.

7. **DHS/OFFICE OF YOUTH SERVICES ONLY:** For the program with an asterisk (*) on the top of page 1:

    a. *Send* ORIGINAL completed DHS 1507 to CWS FHLU;

    b. *Mail* photocopy to the requesting agency; and

    c. *Retain* photocopy and *file* for future reference.

FORM SUPPLY:

DHS 1507 shall be photocopied as needed or may be downloaded from the DHS website: **http://hawaii.gov/dhs/backgroundcheck**

STATE OF HAWAII / DEPARTMENT OF HUMAN SERVICES / SOCIAL SERVICES DIVISION

PROGRAMS: CHECK ONE ONLY:

(* ITS: Forward original results to CWS FHLU-See page 2, and mail copy to requesting agency)

- ☐ CCFFH/CMA
- ☐ ACCS General
- ☐ ACCS Out-of-State Request
- ☐ Adult Day Care Center
- ☐ Foster Grandparent
- ☐ Senior Companion
- ☐ Respite Companion
- ☐ DOH-ADAD
- ☐ DOH-AMHD
- ☐ DOH-OHCA
- ☐ DOH-DDD
- ☐ DOH-CAMHD (Other Than Ther.Hms/Staff)
- ☐ DHS-Med-QUEST (Other Than DOH- DDD)
- ☐ DHS-Office of Youth Services (Other Than Safe House Staff)
- ☐ DHS-Office of Youth Services Safe House Staff (P)*

AUTHORIZATION TO RELEASE INFORMATION FROM THE ADULT/CHILD PROTECTIVE SERVICES CENTRAL REGISTRY

REQUESTING INDIVIDUAL OR AGENCY: (Print or Type all information)

Name: _____ Phone: _____

Address: _____ ATTN: _____

_____ _____

I hereby authorize the Department of Human Services (DHS) or its designee to conduct the following Protective Services Central Registry Check: ☐ **Adult Protective Services (APS)** and/or ☐ **Child Abuse and Neglect (CAN)** on me and to release the information to the requesting individual or agency as indicated above. ** Program with an asterisk: mail copy of results to requesting individual or agency and forward original to CWS FHL Unit noted on the bottom of page 2.*

Full name: _____ Date of Birth: _____

Social Security Number: _____ Telephone Number: _____

Any Alias(es)/Former Name, including Maiden Name: _____

_____

Current Address: _____

The information to be released shall be limited to the history of abuse or neglect in which I was identified as a perpetrator and shall include date(s) of CONFIRMED incident(s) only and type of abuse for each incident.

I understand that the information I provide about me shall be used solely for the purpose of conducting the APS and/or CAN Protective Services Central Registry Check. I also understand that the release of this information may be used as part of a background check for employment, volunteer, licensure, or certification purposes which may result in suspension or termination.

This authorization is good until _____/_____/_____ or _____.
Date Event

When no date or event is specified, the authorization shall expire one year from the date the authorization is signed.

Signature: _____ **Date:** _____

Mail or FAX the completed form to: Insights to Success, P. O. Box 1290, Honolulu, Hawaii 96807; or FAX: 532-8331. If you have questions, please call: OAHU: 532-8322 or Neighbor Islands: (877) 532-8322.

**********FOR OFFICIAL USE ONLY**********

Full Name: _____ **Date of Birth:** _____

APS Central Registry Clearance: **The following results are based upon the information provided on Page 1:**

Type(s) of Confirmed Adult Abuse or Neglect:	**Date(s) of Confirmation:**
☐ Caregiver Neglect (Negligent Treatment/Maltreatment)	_____
☐ Financial Exploitation	_____
☐ Physical Abuse	_____
☐ Psychological Abuse	_____
☐ Self-Neglect (Poor Self-Care)	_____
☐ Sexual Abuse	_____

☐ APS CHECK NOT REQUESTED ☐ NO RECORD OF CONFIRMED ADULT ABUSE ON FILE

CAN Central Registry Clearance: **The following results are based upon the information provided on Page 1:**

Type(s) of Confirmed Child Abuse or Neglect:	**Date(s) of Confirmation:**
☐ Physical Harm/Abuse	_____
☐ Failure to Thrive	_____
☐ Threatened Physical Harm/Abuse	_____
☐ Physical Neglect	_____
☐ Abandonment	_____
☐ Lack of Supervision	_____
☐ Medical Neglect	_____
☐ Threatened Physical Neglect	_____
☐ Sex Abuse	_____
☐ Threatened Sex Abuse	_____
☐ Psychological Harm	_____
☐ Abuse	_____
☐ Neglect	_____
☐ Threatened Psychological Harm	_____
☐ Providing a child with dangerous, harmful, or detrimental drugs as defined by Section 712-1240	_____

☐ CAN CHECK NOT REQUESTED ☐ NO RECORD OF CONFIRMED CAN ON FILE

Clearance Completed by: _____ Date: _____
DHS or Designee Worker's Name Phone Number

* *Program with asterisk: Mail copy of results to requesting agency and forward original results to CWS FHLU.*
CWS FHL Unit Address:
420 Waiakamilo Road, Suite 300B
Honolulu, Hawaii 96817